

Registration District No. 816

Primary Registration District No. 2001

Registrar's No. 33

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution: 617-N-FRANKLIN
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 617-N-FRANKLIN 50 yrs
years, months or days

3. (a) PRINT FULL NAME OLIVER BROWN

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Dec. years 24 1865
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 16 If less than one day hr. min.

9. Birthplace: Nixa (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Travis Brown
13. Birthplace Unknown Unknown
14. Maiden name Susan (Unknown)
15. Birthplace Unknown Unknown

16. (a) Informant Sam Brown
(b) Address 641 - Franklin

17. (a) Burial (b) Date thereof 1-13-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Plainville Cemetery

18. (a) Signature of funeral director H. E. Handley
(b) Address 702 - N - Jefferson

19. (a) 1-13-41 (b) H. E. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limit, write "RURAL")
(d) Street No. 617 - N - Franklin
(If rural, give location)
(e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 10
year 1941 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from 19 to 19
that I last saw him alive on Jan 10
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis
died in this sleep

Due to
Due to

Other conditions: Senility
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury
Signature R. E. White (M. D. or other)
Address Corner Greene County Date signed 1/10/41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

H. V. Smith....., Registered Apprentice No.
working under my personal supervision.

Signed..... Herbert V. Smith

Licensed Embalmer No. 3324

P. O. Address 702 - 28 - 11th St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.